



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHC ON BEHALF OF
NORTHEAST METHODIST HOSPITAL
10002 BATTLEVIEW PARKWAY
MANASSAS VA 20109

Carrier's Austin Representative Box
01

MFDR Date Received

JANUARY 21, 2003

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number

M4-03-2384-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated January 21, 2003: "Claim should be paid at 75% as bill exceeds 40k."

Amount in Dispute: \$35,287.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 6, 2002: "The bill and documentation attached to the medical dispute has been re-reviewed and our position remains the same. Upon initial review of the billing, it was determined that the charge billed for the implants appeared inflated. The total charge for implants was deducted from the total billed charge. The implants were re-priced to usual and customary and added back to the total billed charge. When the implants were repriced to usual and customary and added back to the billed charges, the total billed charges were far below the stop loss threshold, so the facility was reimbursed per the Texas Fee Schedule Surgical per diem plus implants at usual and customary."

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Road, Gainesville, GA 30504

Respondent's Supplemental Position Summary Dated October 18, 2004: "I have been retained by Liberty Mutual Fire Insurance to represent them in connection with the enclosed medical payment dispute, which was decided upon by the Medical Review Division. Liberty Mutual Fire Insurance does not agree with the disposition of this dispute and respectfully requests a hearing in connection therewith to present further evidence on its behalf."

Response Submitted by: Hanna & Plaut, L.L.P., 106 East Sixth Street, Suite 600, Austin, TX 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 3, 2002 through September 7, 2002	Inpatient Hospital Services	\$35,287.43	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code rules §133.305 and §133.307, 26 *Texas Register* 10934, applicable to requests filed on or after January 1, 2002, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- F, Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
- F, Z560-The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix.
- F, Z782-Payment reduced due to lack of wholesale invoice.
- F, X394-Our position remains the same; if you disagree with our decision please contact the TWCC medical dispute resolution.

Dispute M4-03-2384-01 was originally decided on October 5, 2004 and subsequently appealed to a judicial hearing at the 345th Judicial District under case number D-1-GN-08-002682. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to a January 30, 2012 Judicial District order of remand. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill

review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$81,807.64. The Division concludes that the total audited charges exceed \$40,000.

2. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The Third Court of Appeals’ November 13, 2008 opinion states that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services” and further states that “...independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestor in its original position statement states that “Claim should be paid at 75% as bill exceeds 40k.” This statement does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor presumes that the disputed services meet Stop-Loss, thereby presuming that the admission was unusually extensive. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).
3. 28 Texas Administrative Code §134.401(c)(6) states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The Third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. The requestor’s position statement does not address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was four days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of four days results in an allowable amount of \$4,472.00.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).”
 - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$64,776.00.
 - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Screw, 1.8mm TI Locking	2	No support for cost/invoice	\$0.00
Plate 20mm	1	No support for cost/invoice	\$0.00
Screw Cancellous 4.35	4	\$300.00/each	\$1,320.00
TI Buttress Lock Plate	1	No support for cost/invoice	\$0.00
Cage Lum Wedge IF9x11x	4	No support for cost/invoice	\$0.00
K Wires Th .062	2	No support for cost/invoice	\$0.00

If Cage 9x9x25	2	No support for cost/invoice	\$0.00
TOTAL	16		\$1,320.00

The division concludes that the total allowable for this admission is \$5,792.00. The respondent issued payment in the amount of \$26,068.30. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement .

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	11/09/2012
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	11/09/2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service* demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.